

Plan of Correction

Program Name: Brookings Behavioral Health & Wellness	Date Submitted: 01/05/2021	Date Due: 12/27/2020
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Administrative POC-1	
Rule #: 67:61:06:02 67:62:07:02	Rule Statement: <p>Guaranteed rights. A client has rights guaranteed under the constitution and laws of the United States and the state of South Dakota including:</p> <ul style="list-style-type: none"> (1) The right to refuse extraordinary treatment as provided in SDCL 27A-12-3.22; (2) The right to be free of any exploitation or abuse; (3) The right to seek and have access to legal counsel; (4) To have access to an advocate as defined in subdivision 67:61:01:01(4) or an employee of the state's designated protection and advocacy system; (5) The right to confidentiality of all records, correspondence, and information relating to assessment, diagnosis, and treatment in accordance with the confidentiality of records requirements of the Substance Abuse and Mental Health Services Administration, 42 U.S.C. §§ 290 dd-2 (January 7, 2011), the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2 (June 9, 1987), and the security and privacy of HIPAA, 45 C.F.R. Part 160 and 164 (September 26, 2016); and (6) The right to participate in decision making related to treatment, to the greatest extent possible.
Area of Noncompliance: (4) To have access to an advocate as defined in subdivision 67:61:01:01(4) or an employee of the state's designated protection and advocacy system; This is missing from the policy and procedure book	
Corrective Action (policy/procedure, training, environmental changes, etc): Agency policy CP-2 Client Orientation has been updated to include the rule statement above. The agency board of directors has approved the policy and staff has been provided the updated policy for inclusion in ALL center policy manuals.	Anticipated Date Achieved/Implemented: Date 12/30/2020
Supporting Evidence: See attached policy document CP-2 Client Orientation	Position Responsible: Executive Director
How Maintained: Policy CP-2 will be reviewed on an annual basis along with the full agency policy manual.	Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-2	
Rule #: 67:61:05:01	Rule Statement: <p>Tuberculin screening requirements. Tuberculin screening requirements for employees are as follows:</p> <p>(1) Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or</p>

	<p>volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test;</p> <p>(2) A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease;</p> <p>(3) Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of <i>Mycobacterium tuberculosis</i>. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and</p> <p>(4) Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.</p>	
Area of Noncompliance: New employees did not complete the TB two-step method or provide a blood assay test with 14 days of hire.		
Corrective Action (policy/procedure, training, environmental changes, etc): Current policies remain in effect as they require the completion of a TB two-step method test within 14 days of hire. Materials on the process for completing a two-step TB test have been gathered from the Centers for Disease Control (CDC) website and will be used to train medical and administrative staff.		Anticipated Date Achieved/Implemented: Date 01/31/2021
Supporting Evidence: CDC guidance on two-step method; training sign off sheet.		Position Responsible: Executive Director
How Maintained: This processed will be reviewed on an annual basis with the review of center policies and procedures.		Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-1	
Rule #: 67:61:07:10 67:62:08:14	Rule Statement: Transfer or discharge summary. An addiction counselor or counselor trainee shall complete a transfer or discharge summary for any client within five working days after the client is discharged regardless of the reason for discharge. A transfer or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan is maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. When a client prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the client into services if appropriate.
Area of Noncompliance: Three out of four CYF chart and four out of five SUD charts did not document attempts to re-engage the client into services.	

Corrective Action (policy/procedure, training, environmental changes, etc): Current clinical policies and procedures stipulate the completion of a transfer or discharge summary and it is the expectation that reasonable attempts be made and documented to re-engage the client into services if appropriate. Training on this policy will be provided to all clinical staff by the Clinical Director and the Substance Use Services Director. Additionally, monthly QA audits are being completed per center policy and it will be the responsibility of the Clinical Director to identify missing documentation and work with clinical staff to correct records as appropriate.	Anticipated Date Achieved/Implemented: Date 01/31/2021
Supporting Evidence: Center policies: CP-1; CP-3; SUD-4	Position Responsible: Clinical Director
How Maintained: Center policies will be reviewed on an annual basis with the complete agency policy manual. Additionally, monthly QA reviews and quarterly chart audits will be completed by the Clinical Director.	Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-2	
Rule #: 67:61:07:06 67:62:08:07	Rule Statement: Treatment plan. An addiction counselor or counselor trainee shall develop an individualized treatment plan based upon the integrated assessment for each client admitted to an outpatient treatment program, intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically-monitored intensive inpatient treatment program. Evidence of the client's meaningful involvement in formulating the plan shall be documented in the file. The treatment plan shall be recorded in the client's case record and includes: (1) A statement of specific client problems, such as co-occurring disorders, to be addressed during treatment with supporting evidence; (2) A diagnostic statement and a statement of short- and long-term treatment goals that relate to the problems identified; (3) Measurable objectives or methods leading to the completion of short-term goals including: (a) Time frames for the anticipated dates of achievement or completion of each objective, or reviewing progress towards objectives; (b) Specification and description of the indicators to be used to assess progress; (c) Referrals for needed services that are not provided directly by the agency; and (d) Include interventions that match the client's readiness for change for identified issues; and (4) A statement identifying the staff member responsible for facilitating the methods or treatment procedures. Mental Health treatment plans need to be completed within 30 days of intake. The individualized treatment plan shall be developed within 30 calendar days of the client's admission for outpatient counseling services program. All treatment plans shall be reviewed, signed, and dated by the addiction counselor or counselor trainee. The signature must be followed by the counselor's credentials.

Area of Noncompliance: All services that were reviewed did not provide evidence of client's meaningful involvement in formulating the treatment plan.	
Corrective Action (policy/procedure, training, environmental changes, etc): Clinical policy SUD-3 Treatment Plan has been revised to reflect state administrative rule. The agency board of directors has approved the policy and staff has been provided the updated policy for inclusion in ALL center policy manuals.	Anticipated Date Achieved/Implemented: Date 1/31/2021
Supporting Evidence: SUD-3 Treatment Plan	Position Responsible: Executive Director
How Maintained: The policy will be reviewed on an annual basis with the full agency policy and procedure manual. Additionally, the Clinical Director will monitor compliance with this policy during monthly QA audits and quarterly full chart audits.	Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-3	
Rule #: 67:61:07:05	<p>Rule Statement:</p> <p>Integrated assessment. An addiction counselor or counselor trainee shall meet with the client and the client's family if appropriate, to complete an integrated assessment, within 30 days of intake. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and shall assess the client's treatment needs. The assessment shall be recorded in the client's case record and includes the following components:</p> <ol style="list-style-type: none"> (1) Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable; (2) Presenting problems or issues that indicate a need for services; (3) Identification of readiness for change for problem areas, including motivation and supports for making such changes; (4) Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization; (5) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history; (6) Family and relationship issues along with social needs; (7) Educational history and needs; (8) Legal issues; (9) Living environment or housing; (10) Safety needs and risks with regards to physical acting out, health conditions, acute intoxication, or risk of withdrawal; (11) Past or current indications of trauma, domestic violence, or both if applicable; (12) Vocational and financial history and needs; (13) Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present; (14) Formulation of a diagnosis, including documentation of co-occurring medical,

	<p>developmental disability, mental health, substance use disorder, or gambling issues or a combination of these based on integrated screening;</p> <p>(15) Eligibility determination, including level of care determination for substance use services, or SMI or SED for mental health services, or both if applicable;</p> <p>(16) Clinician's signature, credentials, and date; and</p> <p>(17) Clinical supervisor's signature, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or formulation of the initial diagnosis in cases where the staff does not have the education or training to make a diagnosis.</p> <p>Any information related to the integrated assessment shall be verified through collateral contact, if possible, and recorded in the client's case record.</p>
<p>Area of Noncompliance: Two components, the Living Environment/Housing and Indications of Trauma/Domestic violence were consistently missing in the integrated assessment. Eight out of 15 client files did not include these two components. Other components were also sporadically missing.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): Clinical policy SUD-3 Treatment Plan has been revised to reflect state administrative rule. The agency board of directors has approved the policy and staff has been provided the updated policy for inclusion in ALL center policy manuals.</p>	<p>Anticipated Date Achieved/Implemented:</p> <p>Date 12/30/2020</p>
<p>Supporting Evidence: SUD-1 Admission Process</p>	<p>Position Responsible: Executive Director</p>
<p>How Maintained: The policy will be reviewed on an annual basis with the full agency policy and procedure manual. Additionally, the Clinical Director will monitor compliance with this policy during monthly QA audits and quarterly full chart audits.</p>	<p>Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Client Chart POC-4	
<p>Rule #: 67:61:07:12</p>	<p>Rule Statement: Tuberculin screening requirements. A designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment, intensive outpatient, day treatment, clinically-managed low intensity residential treatment, clinically managed detoxification, and intensive inpatient treatment within 24 hours of admission to determine if the client has had any of the following symptoms within the previous three months:</p> <ul style="list-style-type: none"> (1) Productive cough for a two to three-week duration; (2) Unexplained night sweats; (3) Unexplained fevers; or (4) Unexplained weight loss. <p>Any client determined to have one or more of the above symptoms within the last three months shall be immediately referred to a licensed physician for a medical evaluation to determine the absence or presence of active disease. A Mantoux skin test may or may not be done during this evaluation based on the opinion of the evaluating physician. Any client confirmed or suspected to have infectious tuberculosis shall be excluded from services until the client is determined to no longer be infectious by the physician. Any client in which infectious tuberculosis is ruled out shall provide a written statement from the evaluating</p>

	physician before being allowed entry for services.
Area of Noncompliance: Three out of 14 clients did not have the TB screening completed.	
Corrective Action (policy/procedure, training, environmental changes, etc): Current agency policies and procedures stipulate the completion of a TB screening upon admission. Training on this policy will be provided to all center staff by the Clinical Director. Additionally, monthly QA audits are being completed per center policy and it will be the responsibility of the Clinical Director to identify missing documentation and work with clinical/administrative staff to correct records as appropriate.	Anticipated Date Achieved/Implemented: Date 12/30/2020
Supporting Evidence: CP-2 Client Orientation; Form F-TB screening	Position Responsible: Clinical Director
How Maintained: Center policies will be reviewed on an annual basis with the complete agency policy manual. Additionally, monthly QA reviews and quarterly chart audits will be completed by the Clinical Director.	Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-5	
Rule #: 67:61:07:08	Rule Statement: Progress notes. All programs, except prevention programs, shall record and maintain a minimum of one progress note weekly, when services are provided. Progress notes are included in the client's file and substantiate all services provided. Individual progress notes must document counseling sessions with the client, summarize significant events occurring, and reflect goals and problems relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes must include attention to any co-occurring disorder as they relate to the client's substance use disorder. A progress note must be included in the file for each billable service provided. Progress notes must include the following for the services to be billed: (1) Information identifying the client receiving the services, including the client's name and unique identification number; (2) The date, location, time met, units of service of the counseling session, and the duration of the session; (3) The service activity code or title describing the service code or both; (4) A brief assessment of the client's functioning; (5) A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues for the purpose of achieving identified treatment goals or objectives; (6) A brief description of what the client and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and (7) The signature and credentials of the staff providing the service.
Area of Noncompliance: Four out of 13 SUD client charts did not have a weekly progress note.	
Corrective Action (policy/procedure, training, environmental changes, etc): New clinical policy has been developed to reflect the administrative rule above. SUD-6 Progress Notes. The agency board of directors has approved the policy and staff has been provided the updated policy for inclusion in ALL	Anticipated Date Achieved/Implemented: Date 12/30/2020

center policy manuals.	
Supporting Evidence: Clinical Policy SUD-6	Position Responsible: Executive Director
How Maintained: The policy will be reviewed on an annual basis with the full agency policy and procedure manual. Additionally, the Clinical Director will monitor compliance with this policy during monthly QA audits and quarterly full chart audits.	Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-4	
Rule #: 67:61:07:07	<p>Rule Statement:</p> <p>Continued Service Criteria: The program shall document for each client the progress and reasons for retaining the client at the present level of care; and an individualized plan of action to address the reasons for retaining the individual in the present level of care. The document is maintained in the client case record. It is appropriate to retain the client at the present level of care if :</p> <ol style="list-style-type: none"> (1) The client is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or (2) The client is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward he goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or (3) New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only be delivered by continued stay in the current level of care. The level of care in which the client is receiving treatment is therefore, the least intensive level at which the client's new problems can be addressed effectively. <p>The individualized plan of action to address the reason for retaining the individual in the present level of care shall be documented every:</p> <p>30 calendar days for: Outpatient treatment services</p>
Area of Noncompliance: The continued service criteria was not documented every 30 days for eight out of 11 clients who received level 1.0 care.	
Corrective Action (policy/procedure, training, environmental changes, etc): New clinical policy has been developed to reflect the administrative rule above. SUD-5 Continued Service Criteria. . The agency board of directors has approved the policy and staff has been provided the updated policy for inclusion in ALL center policy manuals.	<p>Anticipated Date Achieved/Implemented:</p> <p>Date 12/30/2020</p>
Supporting Evidence: Clinical Policy SUD-5	Position Responsible: Executive Director

How Maintained: The policy will be reviewed on an annual basis with the full agency policy and procedure manual. Additionally, the Clinical Director will monitor compliance with this policy during monthly QA audits and quarterly full chart audits.

Board Notified:

Y ☒ N ☐ n/a ☐

Program Director Signature: Mary E. Fishback

Date:

01/05/2021

Please email or send Plan of Correction to:

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